Department of Veterans Affairs **VHA DIRECTIVE 2005-030**
Veterans Health Administration
Washington, DC 20420 **July 8, 2005**

COMPLIANCE AND BUSINESS INTEGRITY (CBI) ANNUAL REPORT

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policies and procedures for the creation, modification, and submission of the Compliance and Business Integrity (CBI) Annual Report for each fiscal year (FY).

2. BACKGROUND

a. VHA is committed to the goal of being recognized in the health care industry as achieving the highest standards of business integrity, particularly in its practices of collecting funds from third-party health benefit plans and co-payments from certain veterans. The CBI Program provides system leadership with reasonable assurance as to whether operational systems exist to achieve this high standard of business integrity.

b. VHA Directive 2003-028, Compliance and Business Integrity CBI Program requires that VA Medical Center CBI Officers (CBIOs) "provide a report, at least annually, to the Veterans Integrated Service Network (VISN) CBIOs," and that the VISN CBIO "provide a report, at least annually, to the VHA Director, CBI."

c. The CBI Annual Report assists the national CBI program in monitoring and trending field CBI efforts and evaluating their effectiveness. The CBI Annual Report is an essential component of the national CBI's assessment of whether operational systems exist to achieve high standards of business integrity.

d. At the March 2005 meeting, the national Compliance Advisory Board (CAB) recommended, and the Acting Under Secretary for Health concurred, that the Director, CBI should identify elements in the CBI Annual Report which are so crucial to programmatic success as to be mandatory for VA Medical Center CBI Programs. At the March 24, 2005, meeting of the Executive Committee of the National Leadership Board (NLB), concurrence was obtained for the standardization of core program elements in the CBI Annual Report.

e. The CBI Annual Report is established to meet several major objectives in the compliance and business integrity effort:

(1) To provide a standardized and consistent report, in both format and substance, to facilitate annual reports by VA Medical Center and VISN CBIO as required by VHA Directive 2003-028, Compliance and Business Integrity (CBI) Program.

(2) To provide VHA leadership at the VA Medical Center, VISN, and VA Central Office levels with information regarding the state of facility compliance programs on an annual basis.

THIS DIRECTIVE EXPIRES MAY 31, 2008

(3) To provide standard and consistent information to CAB and the CAB Certification Subcommittee for their use in reporting to the Executive Committee of NLB.

(4) To provide a standardized database of CBI program elements to facilitate the evaluation and assessment of the effectiveness of CBI programs, and assessment of those program elements that make the most difference in compliance outcomes.

(5) To promote excellence in the compliance arena by highlighting best practices, supporting program effectiveness, and providing a vehicle for marketing effective compliance strategies in VHA.

Note: *The CBI Annual Report will identify a minimum set of program elements that are expected to be present in all facility-level CBI programs. These mandatory elements will be clearly identified on the CBI Annual Report each FY. Attachment A defines how the Director, CBI will determine which elements are mandatory. Mandatory elements are subject to change annually. Attachment B contains the FY 2005 CBI Annual Report. This attachment is subject to change annually.*

3. POLICY: It is VHA policy that, consistent with Directive 2003-028, VA Medical Center CBIOs will complete an annual report with defined mandatory program elements for submission through the VISN CBIO to the VA Central Office Director, CBI, documenting CBI activity and accomplishments at their VA Medical Center for the previous FY.

4. ACTION

a. **Director, CBI.** The Director, CBI is responsible for:

(1) Identifying key program elements of a CBI program to be reported for each FY.

(2) Identifying the specific program elements in the CBI Annual Report which will be considered mandatory.

(3) Creating and distributing a standard format for the CBI Annual Report.

(4) Receiving and analyzing completed CBI Annual Reports from each CBIO.

(5) Identifying key strengths and weaknesses in the compliance effort and promoting improved practices.

(6) Identifying best practices in the compliance arena and promoting their use throughout the VHA system.

(7) Reporting the results and analysis of the CBI Annual Report to CAB.

b. **Compliance Advisory Board (CAB).** CAB is responsible for:

(1) Receiving the results of the CBI Annual Report from the Director, CBI.

(2) Proposing further action as appropriate.

(3) Identifying and analyzing trends in the compliance effort and advising VHA CBI on further action.

(4) Communicating results and proposed improvements to the Under Secretary for Health (10), the Deputy Under Secretary for Health for Operations and Management (10N) as well as the NLB.

c. **VISN CBIO.** The VISN CBIO is responsible for:

(1) Assisting VA Medical Center CBIOs in reporting information where VISN-wide initiatives affect the information reported.

(2) Communicating VISN reports and analysis to the Network Director and the Network Compliance Committee.

(3) Advising with VA Medical Center CBIOs to implement best practices within their facilities to achieve an effective CBI program within the VISN as a whole, and VISN leadership whether operational systems exist to achieve high standards of compliance and business integrity.

(4) Reviewing, approving, and forwarding to the Director, CBI, each VA Medical Center CBI Annual Report not later than the end of October of each year.

(5) Receiving feedback from the Director, CBI and communicating that feedback to the VA Medical Center CBIOs.

(6) Analyzing reports and providing trended data to the Network Compliance Committee.

d. **VA Medical Center CBIO.** The VA Medical Center CBIO is responsible for:

(1) Completing and submitting the CBI Annual Report each October.

(2) Reporting results of the CBI Annual Report to the VA Medical Center Director and the VA Medical Center Compliance Committee.

(2) Transmitting the VA Medical Center's CBI Annual Report to the VISN CBIO for review, approval, and transmission to the Director, CBI.

(3) Receiving feedback and guidance from the VISN CBIO.

(4) Advising and coordinating with VA Medical Center management and other departments to achieve an effective CBI program at the VA Medical Center and advising VA Medical Center

leadership whether operational systems exist to achieve high standards of compliance and business integrity.

5. REFERENCES

a. VHA Directive 2003-028, Compliance and Business Integrity (CBI) Program, May 29, 2003.

b. Department of Health and Human Services (HHS) Office of Inspector General (OIG) Compliance Program Guidance for Hospitals, 63 Federal Register (FR) 8987 (February 23, 1998).

c. HHS OIG Supplemental Compliance Program Guidance for Hospitals, 70 FR 4858 (January 31, 2005).

d. HHS OIG Compliance Program Guidance for Third-Party Medical Billing Companies, 63 FR 70138 (December 18, 1998).

e. HHS OIG Compliance Program Guidance for Nursing Facilities, 65 FR 14289 (March 16, 2000).

f. HHS OIG Compliance Program Guidance for Individual and Small Group Physician Practices, 65 FR 59434 (October 5, 2000).

g. HHS OIG Provider Self-Disclosure Protocol, 63 FR 58399 (October 30, 1998).

h. HHS OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 68 FR 23731 (May 5, 2003).

i. United States Sentencing Commission, Sentencing Guidelines, Chapter 8, Sentencing of Organizations at http://www.ussc.gov/2004guid/CHAP8.pdf

6. FOLLOW-UP RESPONSIBILITY: The Director, CBI (10B3), is responsible for the contents of this Directive. Questions may be addressed to (202) 501-1831.

7. RESCISSIONS: None. This Directive expires May 31, 2008.

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Under Secretary for Health

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ATTACHMENT A

CRITERIA FOR COMPLIANCE AND BUSINESS INTEGRITY (CBI) MANDATORY ELEMENTS

1. Program elements designated as mandatory in the Compliance and Business Integrity (CBI) Annual Report document must be implemented at each VA Medical Center not later than the end of the fiscal year (FY) they are identified as such. If a facility has not implemented a mandatory element by the close of any FY, it will attach a CBI Action Plan to the CBI Annual Report showing how it will implement the mandatory element in the subsequent FY, and include a timeline for completion.

2. The CBI Annual Report will have a consistent format as defined by the Director, CBI and will be submitted in October of each year. Specific reporting dates will be established each year by the Director, CBI.

3. Mandatory elements are to be defined as those program elements:

a. Which are contained in Veterans Health Administration (VHA) Directives and Handbooks.

b. As specifically referenced in VHA Directive 2003-028, Compliance and Business Integrity Program, those program elements which are contained in the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Compliance Program Guidance for Hospitals, 63 FR 8987 (February 23, 1998), as supplemented at 70 FR 4858 (January 31, 2005).

c. Which are determined by the Director, CBI to be so fundamentally important to program integrity as to be deemed essential for program effectiveness. In making such determinations, the Director, CBI will consider:

(1) Program elements identified by the Guidelines of the U.S. Sentencing Commission relating to Effective Compliance and Ethics Programs.

(2) Program elements, as applicable to specific aspects of VHA clinical and business operations, as identified by the HHS OIG in:

(a) Compliance Program Guidance for Third-Party Medical Billing Companies, 63 FR 70138 (December 18, 1998).

(b) Compliance Program Guidance for Nursing Facilities, 65 FR 14289 (March 16, 2000).

(c) Compliance Program Guidance for Individual and Small Group Physician Practices, 65 FR 59434 (October 5, 2000).

(d) Provider Self-Disclosure Protocol, 63 FR 58399 (October 30, 1998).

(e) Compliance Program Guidance for Pharmaceutical Manufacturers, 68 FR 23731 (May 5, 2003).

(3) Program elements identified by industry-standard consensus resources as essential elements of an effective compliance or business integrity program. Industry-standard consensus resources include, but are not limited to, the publications of the Health Care Compliance Association, the Health Ethics Trust, the Ethics Resource Center, the Ethics Officers Association, the American Health Lawyers Association, and the Journal of Health Care Compliance.

(4) Program elements identified, via Annual Reports or otherwise, as common to CBI programs which have a demonstrable high level of effectiveness.

VHA Office of Compliance and Business Integrity
FY 2005 CBI Annual Report

Notes:

1. The terms "plan" and "policy" are used throughout this document. To be considered as evidence that a CBI program element has been established, a plan or policy must be a written, formal document signed by the appropriate individual within the organization, generally the VAMC or VISN Director.

- *"Policy" refers to a document produced at the local level outlining the implementation of a program, such as Training and Education, including rules, regulations and mandated program elements.*
- *"Plan" refers to a facility specific, year specific plan of what the compliance program will do in a specific program. For example, a Training and Education Plan outlines who will be trained, using what resources and at what times and dates in a specific year. Although the facility may not refer to program documents as a plan or policy, many programs have elements that are mandated by written documents.*
- *If the facility has any document that clearly describes the process, creation or accomplishment of the elements addressed in this report, please attach when asked for documentation.*
- *This report should specifically address the program at your facility. Policies, plans, and training should include those within your facility, not limited to the CBI program or developed by the CBI Officer. VISN-level policies may also be attached. If the overall compliance policy addresses the criteria that follow, it is acceptable and considered valid. If this is the case, attach the policy to this report.*

2. A number of program elements are considered so basic to any Compliance and Business Integrity Program that they are considered "mandatory," i.e., that a program lacking such an element is lacking in a fundamental way. "Mandatory" elements are designated with an asterisk. VAMCs and VISNs which do not have mandatory program elements in place as of October 1, 2005 should submit plans to implement them in FY2006.

3. CBI program elements are defined in various sources: some (such as VHA Directives) which are mandatory; some which are required because they are contained in documents (such as HHS OIG Compliance Program Guidance) which are referenced in VHA Directives as a basis for the Directive; some which are essential because they are established in documents (such as Sentencing Commission Guidelines or OMB Circular A-123) considered foundational to CBI programs; and some which are considered important because they bring important management concepts to CBI initiatives.

- *VHA Directives will be referred to by Directive number and section.*
- *The initial HHS OIG Compliance Program Guidance for Hospitals, as referenced in VHA Directive 2003-028[1], was published at 63 FR 8987*

[1] Directive 2003-028, Sections 2(c), (d); 5.

(February 23, 1998) and will be referred to as "IG Guidance" along with section and FR page number.[2]

- *The HHS OIG Supplemental Compliance Program Guidance for Hospitals was published at 70 FR 4858 (January 31, 2005) and will be referred to as "Supp. IG Guidance" along with section and FR page number.*[3]
- *U.S. Sentencing Commission Guidelines can be found at, and will be referred to as "Sentencing Guidelines" along with section number.*[4]

[2] A .PDF of the IG Guidance is on the VACO CBI Website under "Compliance Resources" and can also be downloaded from http://frwebgate5.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=709134388543+0+1+0&WAISaction=retrieve.

[3] A .PDF of the Supplemental Guidance is available from the VACO CBI Website under "Compliance Resources" and can also be downloaded from: http://frwebgate4.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=7106825780+0+1+0&WAISaction=retrieve.

[4] A link to the Sentencing Guidelines is on the VACO CBI Website under "Compliance Resources," they can be downloaded from: http://www.ussc.gov/2004guid/TABCON04.htm.

Compliance Officer and Committee

The Compliance and Business Integrity (CBI) Officer and Compliance Committee are integral parts of the compliance program. In order to be effective, the CBI officer and committee must have access to the right people and tools to be able to accurately measure the compliance program's impact on the organization. The CBI Officer reports to the Facility Director and is in a position to get the necessary information to make an informed decision about the possible actions he or she should take within the facility to ensure compliance. The CBI officer is also unencumbered from excess collateral duties and pursues continuing education in compliance through VA and other educational forums. The Compliance Committee is comprised of trained representatives from each of the relevant functional departments including Business Office and HIM functions. The Compliance Committee reviews all aspects of the compliance program including all policies and annual compliance plans (e.g. Training and Education), results of any investigations and audits, the CBI Supporting Indicators and all corrective action taken throughout the year.

1. Please check "Yes" for each element below that was true about your facility's CBI Officer[5] in FY 2005. If the element was not true of the CBI Officer, please check "No" and explain how, or whether, you plan to accomplish the task next fiscal year:
    a. *The CBI Officer reported to the Facility Director.[6]
    b. The Compliance Officer dedicated 100% of his/her time to compliance or compliance-related activities.[7]
    c. *If the CBI Officer had collateral duties, was there a written process to address when collateral duties could conflict with or impair his or her ability to perform primary program requirements?[8]

[5] VHA Directive 2003-028 requires CBI Officers at VISNs: Section 4(d)(1), and VAMCs: Section 4(f)(1); also OIG Guidance at 8993, Section II(B)(1), Supp. IG Guidance at 4874, Section III(A)(1), Sentencing Guidelines at Section 8B2.1(b)(2)(B).

[6] VHA Directive 2003-028, Section 3(e)(3) [VISN]; 3(g)(2) [VAMC]. When Directive 2003-028 was drafted, some VAMC Directors were using titles other than "Director," such as "CEO", thus the Directive used the words "or equivalent" to take into account the variation in titles which no longer exists. Also, IG Guidance at 8993, Section II(B)(1), Supp. IG Guidance at 4874, section III(A)(1), and Sentencing Guidelines at Section 8B2.1(b)(2)(B) and (C).

[7] Several documents, including Directive 2003-028, Sections 4(e)(1) and (2) and 4(g)(1) and (2), as well as IG Guidance at 8993, Section II(B)(1) and Supp. IG Guidance at 4874, Section III(B)(1) speak to the need for a compliance officer to assure effectiveness of the CBI program and alignment with the national program, and to have sufficient autonomy and resources (including time) to properly perform the function. At the same time, there is recognition that at smaller sites, a CBI Officer may be able to accomplish the goals of an effective program while still having collateral, *i.e.,* secondary duties. IG Guidance at 8993, Section II(B)(1); Sentencing Guidelines, at Section 8B2.1(a)(2) and *Commentary*, Sections 2(A) and (C).

[8] IG Guidance at 8993, Section II(B)(1), and n. 35; Supp. IG Guidance at 4874, Section III(A)(1).

i. Yes.
ii. No.
iii. N/A (the CBI Officer does not have collateral duties).

d. *The CBI Officer received continuing education in compliance through VA sponsored education programs.[9]
e. The CBI Officer received continuing education in compliance through external sources.[10]
f. *The CBI Officer had the necessary tools, resources, training, authority, and autonomy to accurately gauge whether the facility was compliant in any compliance-related field.[11]
g. *The CBI Officer had a good working relationship with key operational areas to include coding, billing, and clinical departments.[12]
h. The CBI Officer held a certification in compliance from a recognized, professional organization. (If yes, please list the certification in the comments field.)[13]

2. **Please attach the CBI Officer's job description, explanation or equivalent.**

3. Please check "Yes" for each element that was true about the *Compliance Committee[14] at the facility in FY 2005. If the element was not true, please check "No" and explain how, or whether, you propose to accomplish the task next year:

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[9] Compliance Officer to be "well qualified": IG Guidance at 8993 Section II(B)(1); Supp. IG Guidance at 4874, Section III(B)(1).

[10] *Ibid.*

[11] Directive 2003-028, Section 4(e)(1) [VISN] and 4(g)(1) [VAMC]; IG Guidance at 8993-4, Section II(B)(1); Supp. IG Guidance at 4874, Section III(A)(1); Sentencing Guidelines, at Section 8B2.1(b)(2)(c).

[12] Supp. IG Guidance, at 4875, Section III(A)(1). The IG Guidance, at 8998, Section I, and Supp. Guidance, at 4874, Section III(A) and particularly III(B)(3) make clear that the responsibility for establishing and maintaining good working relationships is not solely that of the CBI Officer, but is a manifestation of an organizational culture in which compliance is integrated into the fabric of operations. The Committee of Sponsoring Organizations of the Treadway Commission (COSO), recognized nationally for its foundational work on internal control environments, notes that a key element of a good working relationship must be based on management's "clear-cut willingness to listen." See also, Sentencing Guidelines, at Section 8B2.1(a)(2), and (b)(6).

[13] Compliance Officer to be "well qualified": IG Guidance at 8993 Section II(B)(1); Supp. IG Guidance at 4874, Section III(B)(1).

[14] Compliance Committees are required by Directive 2003-028, Sections 4(d)(1) [VISN] and 4(f)(1) [VAMC]; IG Guidance at 8994, Section II(B)(2); Supp. IG Guidance at 4874-5, Section III(A)(1).

a. *The committee included individuals from areas where compliance has or may have influence on policy, procedures, or decision-making.[15]
b. *The committee had a process to review referrals from other VAMC committees and programs that influence business integrity.[16]
c. *The committee was well educated in compliance activities through training and education refresher courses.[17]
d. *The committee was involved in, or informed of, salient investigations, program reviews, external inspections or other recurring or episodic program assessment efforts that fall under the purview of CBI responsibilities.[18]
    i. N/A because none of the above took place in the fiscal year.
e. *Issues of significant importance or compliance violations were forwarded to the VISN CBI Officer or Council.[19]
    i. N/A because there were no issues worthy of reporting to the VISN.
f. *The committee assisted in developing the facility's Risk Assessment, Monitoring and Auditing Plan and Training and Education Plan.[20]
g. *The committee had criteria standards and monitoring processes for collecting, documenting and reporting risk, monitoring, auditing, education, and training information until the outcome criteria are consistently met.[21]
h. *The committee routinely monitored revenue cycle activities as well as identified and audited high-risk areas as required until compliance was consistently demonstrated.[22]
i. *The committee had provisions to meet on an ad hoc basis if an issue arose that needed immediate attention.[23]
j. *The committee reviewed all compliance policies and plans for the year.[24]
k. *The facility director approved all compliance policies.[25]
l. *The committee reviewed the findings of all compliance-related audits and investigations.[26]
m. *The Committee reported to the senior-most committee at the facility at least quarterly.[27]

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[15] IG Guidance at 8994, Section II(B)(2), n. 39; Supp. IG Guidance, at 5874-5, Section III(A)(1).
[16] VHA Directive 2005-021 "VA Medical Center Compliance and Business Integrity (CBI) Committee"
[17] *Ibid.*
[18] *Ibid.*
[19] *Ibid.*
[20] *Ibid.*
[21] *Ibid.*
[22] *Ibid.*
[23] *Ibid.*
[24] IG Guidance, at 8994, Section II(B)(2).
[25] VHA Directive 2005-021
[26] *Ibid.*

n. *The committee provided a written annual CBI program report to senior leadership that encompassed significant work performed during the year and upcoming focus areas that require continued monitoring.[28]
o. *The committee provided to the senior committee at the facility an updated status report on where the organization is with respect to its CBI Annual Report requirements.[29]

4. The following were standing agenda items at every compliance committee meeting if they applied to your facility (i.e. if the facility had no part-time physicians, that criteria would not apply):[30]
    a. *Compliance training and education presentation dates, new programs, attendance and format.
    b. *Findings of all compliance-related audits, investigations, fact-finding efforts, etc.
    c. *Compliance policies and plans that needed review.
    d. *LEIE.
    e. Part-time physician audits.
    f. *Misconduct related to compliance.
    g. *CBI Supporting Indicators.
    h. *Overview of CIRTS entries with length of activity as well as more detailed reports when necessary.
    i. *Background Checks.
    j. *New directives, guidance with respect to compliance.
    k. *CBI Action Plans.
    l. *Error rates/Billing returns.
    m. *High-Value refund requests.

5. Please check “Yes” below each element that was true about the facility. Please check “No” if the element was not true of the facility:
    a. *The facility level compliance committee minutes were forwarded to the VISN CBIO.[31]
    b. *The facility director reviewed the minutes of the compliance committee.[32]

6. *The compliance committee met monthly. (If not, how often?)[33]

7. Who participated in the compliance committee (Check all that apply)?
    a. The facility did not have a compliance committee.
    b. Nursing.[34]

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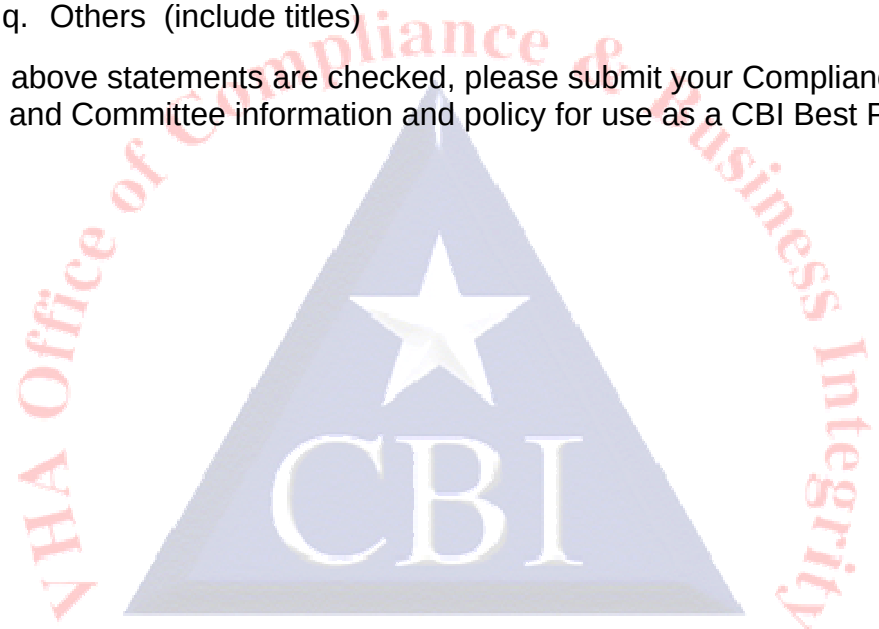
[27] Sentencing Guidelines, *Commentary,* Section 3.

[28] VHA Directive 2005-021
[29] *Ibid.*
[30] As to all sub-elements to this question: VHA Directive 2005-021
[31] VHA Directive 2005-021
[32] *Ibid.*
[33] *Ibid.*

c. CFO or equivalent.[35]
d. Chief, HRM.[36]
e. *Chief, HIM.[37]
f. *Chief, MCCF/R.[38]
g. *Revenue.[39]
h. Representative, Primary Care
i. Representative, Surgical Service
j. Representative, Medical Service.
k. Chief, IRM
l. Representative, Mental Health.[40]
m. Chief, Quality Management.[41]
n. Representative, Regional Counsel.
o. Union Representative
p. Representative, Non-VA Care
q. Others (include titles)

***If all above statements are checked, please submit your Compliance Officer and Committee information and policy for use as a CBI Best Practice.



[34] *Ibid.*
[35] *Ibid.*
[36] *Ibid.*
[37] Memorandum, Deputy Under Secretary for Operations and Management, 12/31/2004.
[38] *Ibid.*
[39] *Ibid.*
[40] IG Guidance at 8994, Section II(B)(2), n. 39.
[41] *Ibid.*

Compliance Training and Education

A model Compliance Training and Education Program is best accomplished with a well-documented facility policy requiring compliance education be provided to all employees. The policy mandates that compliance training be provided to all new employees and job-specific annual refresher training be provided to certain employee groups. In addition, an annual Training and Education Plan is developed at the start of each Fiscal Year. A model Compliance Training and Education Plan is developed using the facility's annual Risk Assessment and includes laws and regulations, organizational alignment of the compliance program, the CBI Helpline, clinical documentation and documentation standards respective to individual job functions, and the results of compliance audits, monitors and investigations. This plan includes new employee education within 60 days of hire, education for volunteers and annual job-related refresher training for managers, medical staff and clinical workers, personnel involved in the coding and billing process, contractors (as appropriate), the compliance committee, executive leaders, and revenue personnel. Another provision is remedial education and training after a compliance exception has been detected. The Training and Education Plan should include the schedule of CBI training and education activities for the coming year. The plan should include the dates or frequency, syllabi, target audience, and materials used for each training session. A tracking system is in place to document the training each employee has received. Training and education is a standing agenda item for the medical center compliance committee.

8. The facility implemented or sustained the following elements of a model training and education program during the past year. Please check "Yes" under all that apply. If they were not true of the facility, please check "No" and explain how, or whether, you plan to accomplish this task next fiscal year.
    a. Documentation of the compliance training and education program:
        i. *A written Training and Education Policy developed at the facility or VISN, which the compliance committee reviewed and the Director approved. (If yes, attach the document.)[42]
        ii. *A written Training and Education Plan for Fiscal Year 2005. (If yes, attach the document.)[43]

9. Please check "Yes" for all elements below that were true of the facility's Compliance Training and Education Program. If they were not true of the facility, please check "No" and explain how, or whether, you plan to accomplish the task next fiscal year:
    a. *Required compliance awareness training for all new employees within 60 days of hire.[44]

[42] Supp. IG Guidance at 4875, Section III(B)(3).
[43] *Ibid.*

b. *The facility provided education to affected employee groups after a compliance exception was detected.[45]
c. *Revenue-cycle volunteers received compliance training.[46]
    i. N/A (because there were no volunteers assigned to revenue-cycle activities.)
d. *A system was in place to track the education each employee had received. (i.e. Tempo, Synquest)[47]
e. *The Training and Education Plan was developed using the risk assessment and auditing and monitoring results to identify business and clinical employees that needed additional training.[48]
f. The facility used The Learning Map in training and education programs.
g. *Regional Counsel participated in, or helped to provide, education involving government ethics and conflicts of interest.[49]

10. Which of the following CIRTS training opportunities did the CBI Officer attend?[50]
    a. CIRTS 101a - How to enter an incident into the CIRTS tool.
    b. CIRTS 101b - Hands-on exercises. Using the fields and major tabs (Incident/Calls/Inquiry) within CIRTS.
    c. CIRTS 201 – Generating reports, tracking and trending data.
    d. None of the above; the CBI Officer attended the initial training during CIRTS rollout.

11. Over the past year, the following employee groups received annual compliance training[51]:
    a. *Personnel who enter codes for billing purposes (Including contracted employees).
        i. N/A because all coding took place at the VISN level

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[44] IG Guidance at 8994, Section II(C), n. 41 and accompanying text; Sentencing Guidelines, Section 8B2.1(b)(4)(A).

[45] Supp. Guidance at 4875, Section III(B)(4); Sentencing Guidelines, Section 8B2.1(b)(7).

[46] IG Guidance at 8994, Section II(C), n. 41 and accompanying text; Sentencing Guidelines, Section 8B2.1(b)(4)(A).

[47] IG Guidance at 8995, Section II(C); Supp. Guidance at 4875, Section III(B)(4).
[48] *Ibid.*

[49] 38 CFR 0.735-1(b); VHA General Counsel Handbook, Section 2.05.

[50] Directives 2001-048 and 2001-051 require that CBI Officers perform certain tasks with respect to the CIRTS tool. Inherent in the obligation to perform such tasks is competence in using the CIRTS tool, derived at least in part from formal training.

[51] As to all sub-elements to this question: IG Guidance at 8994, Section II(C), n. 41 and accompanying text; Supp. IG Guidance at 4875, Section III(B)(4); Sentencing Guidelines, Section 8B2.1(b)(4)(A).

b. *Personnel who produce bills for submission to outside payers (Including contracted employees).
    i. N/A because all billing took place at the VISN level.
c. *Other revenue employees (Including contracted employees).
d. *Physicians and Residents.
e. *Providers other than physicians as indicated by the risk assessment or auditing and monitoring results.
f. *Executive Management.
g. *Clinical Department Heads and Supervisors.
h. *Compliance Committee Members.
i. *Contracting Employees.
j. Other employee groups not listed above (Please Specify).

12. Did the facility include compliance training and education in the scope of work for new independent contractors?[52]
    a. N/A because all contracts were determined at the VISN level.

13. Education provided to employees included the following:
    a. *Applicable laws and regulations.[53]
    b. *The Organizational Compliance Program.[54]
    c. *The CBI Helpline.[55]
    d. *Clinical Documentation.[56]
    e. *Documentation standards respective to the employee's job function (Encounter forms, etc.).[57]
    f. Other topics not listed above (Please Explain).

14. Which methods and tools did you use in compliance training? Choose all that may apply:
    a. Classroom setting.
    b. One-on-one training.
    c. Videos.
    d. V-Tel.
    e. Computer software.
    f. Online websites.

[52] IG Guidance at 8994, Section II(C); Supp. Guidance at 4875, Section III(B)(4); Sentencing Guidelines, Section 8B2.1(b)(4)(B).

[53] IG Guidance at 8995, Section II(C); Supp. Guidance at 4875, Section III(B)(4); Sentencing Guidelines, Section 8B2.1(b)(4)(A).

[54] *Ibid.*
[55] *Ibid.*
[56] *Ibid.*

[57] IG Guidance at 8995, Section II(C), n 41 and accompanying text; Supp. Guidance at 4875, Section III(B)(4); Sentencing Guidelines, Section 8B2.1(b)(4)(A).

g. The facility utilized the monthly Compliance Effectiveness Bulletins and other documents published by Central Office to train staff on applicable regulations, clinical documentation standards, etc.
h. Publications (e.g. Newsletters, bulletins, emails).
i. Other (Please Specify).

15. If any point listed above was accomplished but was not included in the Compliance Training and Education Plan or Policy, please provide documentation of the event.

16. Please provide the proper range for each of the following statements (0-25%, 26-50%, 51-75%, 76-90%, 91-100%) (As of Sept. 30):
    a. Percent of physicians who received training in compliance in the last twelve months.
    b. Percent of revenue cycle staff who received training in compliance in the last twelve months.
    c. Percent of providers (Clinicians and allied health), other than physicians, who received training in compliance in the last twelve months.
    d. Percent of supervisory staff who received training in compliance in the last twelve months.
    e. Percent of executive leadership who received compliance training in the last year.
    f. Average hours spent in compliance training by all employees in the last twelve months (include new employees and existing staff).
        i. One hour or less
        ii. One to three hours
        iii. Three to six hours
        iv. Six hours or more
        v. Don't know

***If your program included all points above, please submit your entire Training and Education Program for use as a CBI Best Practice.

Open Lines of Communication

In order to have a model compliance program, communication must take place between many different individuals within the facility. The facility must foster an organizational culture that encourages and promotes open communication without the fear of retaliation. The CBI Helpline must be adequately promoted using posters, educational materials, written memos addressed to all staff, newsletters and other methods to ensure all employees and patients are aware of this resource. The CBI Officer must participate in discussions about all compliance related aspects of hospital and health system functions and have an integral role in reviews conducted by outside agencies. This includes participating in all entrance and exit interviews conducted by the VA Inspector General, GAO, FAO and JCAHO, as well as other accrediting agencies that evaluate business compliance. The CBI Officer must be informed of all possible compliance exceptions so that he or she can provide assistance and support in resolving the issue. The CBI Officer must, in turn, keep all relevant stakeholders informed of results of all compliance activities and ensure proper follow-up of any suspected compliance violation. These individuals must also be aware of the annual Compliance Risk Assessment so they are conscious of possible compliance "trouble spots" within their organizational units.

17. The facility implemented the following elements of a model Communications Program (Please check "Yes" to all that apply. If they were not true of the facility, please check "No" and explain how, or whether, you plan to accomplish this task next fiscal year):
    a. *The Risk Assessment, was communicated to the executive leadership and managers of each department identified as a potential risk area.[58]
    b. *The Training and Education Plan was communicated to the executive leadership and managers of each department identified for training and education activities.[59]
    c. *The Monitoring and Auditing Plan communicated to the executive leadership and managers of each department identified for monitoring and auditing activities.[60]
    d. *Any other risks identified throughout the year, as well as the plan in place to mitigate that risk, were communicated to executive leadership and managers of each department identified as a potential risk area.[61]

[58] IG Guidance; Section II(B)(1)&(2); Page 8993.
[59] *Ibid*
[60] *Ibid*
[61] *Ibid*

e. *The CBI Officer was involved in the most recent entrance and exit interviews conducted by the VA IG, JCAHO, as well as any other accrediting agencies that evaluate business compliance.[62]
f. *The facility utilized employee exit interviews to ask compliance related questions.[63]
    i. Yes.
    ii. No, used online resource only.
    iii. No, other. (Please explain)
g. *The CBI Officer sat on, or acted as a consultant to, Boards of Investigation within the facility when they concerned Compliance and Business Integrity issues.[64]
    i. N/A (there were no ABIs that concerned CBI issues.)
h. *Clinical providers were informed of any changes to documentation standards that may have affected coding and billing.[65]
i. *There were policies in place that ensured the CBI Officer received copies of any correspondence that suggested systemic or significant insufficiency or inaccuracy in patient registration data, clinical documentation, coding or billing.[66]
j. *The facility had a process for informing the CBI Officer and Committee of refund requests beyond a dollar amount threshold.[67]
    i. Yes, and this was codified in facility policy.
    ii. Yes, but this was not codified in facility policy.
    iii. No.
k. *At what dollar amount was the CBI Officer informed of refund requests?[68] (Must set a threshold)
    i. $500-$999.
    ii. $1,000-$4,999.
    iii. $5,000-$9,999.
    iv. $10,000-$24,999.
    v. $25,000.
    vi. $25,001 or greater.
    vii. No threshold set.

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[62] IG Guidance, Section II(F), page 8996; *cf.,* IG Guidance, Section II(G)(1), page 8997; Supplemental Guidance, Section III(B)(6), page 4876.
[63] All the authorities speak in some way to the obligation of an organization to take reasonable steps to detect misconduct. E.g., IG Guidance, at II(A)(9), page 8993; Sentencing Guidelines, Section 8B2.1(5)(A) and (C) and Commentary, Section 6(A)(1). Asking about knowledge of compliance failures at employment exit interviews is a common tool used in a broad range of regulatory compliance programs.
[64] IG Guidance, Section II(F), page 8996; *cf.,* IG Guidance, Section II(G)(1), page 8997; Supplemental Guidance, Section III(B)(6), page 4876.
[65] Supp. IG Guidance; Section III(B)(4); Page 4875.
[66] Supp. IG Guidance; Section III(B)(1); Pages 4874 – 4875. "Corporate Responsibility and Corporate Compliance;" Page 7.

[67] December 2004 Compliance Advisory Board (CAB) Decision Point
[68] December 2004 Compliance Advisory Board (CAB) Decision Point

l. *The CBI Officer received reports of monitoring by internal business units.[69]
m. *The CBI Officer had ready access to assistance from Regional Counsel.[70]
n. *The CBI Officer provided a copy of the VAMC's Annual CBI Report to the VISN CBI Officer.[71]

18. The Compliance Department promoted the CBI Helpline in the following ways:
    a. *Posters were displayed in employee and other appropriate areas such as patient waiting areas, break rooms, revenue office, etc.[72]
    b. The Helpline was addressed by the CBI Officer in newsletters, flyers, memos, etc.
    c. *The Helpline was highlighted as a topic at other compliance awareness training activities.[73]
    d. Other (please specify).

19. *Was there a process for involving Regional Counsel when serious compliance exceptions were uncovered?[74]

20. *The CBI Officer participated in multidisciplinary committees within the facility.[75]

21. Place a check next to each committee in which the CBIO participated (committee names may differ at your facility, but the functions were very similar, please refer to the Definition of Terms for an explanation of each):
    a. Executive Leadership Board or equivalent.
    b. Data Validation or equivalent.
    c. Privacy or equivalent.
    d. Policy Board or equivalent.
    e. *Network Compliance Council or equivalent.[76]
    f. Education Committee or equivalent.
    g. *MCCF/R or equivalent.[77]
    h. *HIMS or equivalent.[78]
    i. Others not listed above.

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[69] Supp. IG Guidance; Section III(B)(1); Pages 4874 – 4875. "Corporate Responsibility and Corporate Compliance;" Page 7.

[70] Supp. IG Guidance; Section III(B)(1); Page 4874.
[71] VHA Directive 2003-028; Item 4g(4).
[72] Supp. IG Guidance; Section III(B)(3); Page 4875.
[73] *Ibid.*
[74] "An Integrated Approach to Corporate Compliance;" Page 2.
[75] IG Guidance; Section II(B)(1); Page 8993
[76] CBIO on Compliance Committee: Supplemental Guidance, Section III(B)(1), (2), pp. 4874, 4875;
[77] Memo, Deputy Under Secretary for Health – Operations and Management, Dated December 30, 2004
[78] *Ibid.*

22. *The Compliance Officer participated in multidisciplinary forums at the facility.[79]

23. Did the Compliance Officer participate in the following multi-disciplinary forums? (Membership is not required, did you attend?)
    a. Morning Report
    b. Quadrad/Triad
    c. Administrative Executive Board
    d. Clinical Executive Board
    e. Others (please specify)

***If your program included all points above, please submit your Communication Policy for use as a CBI Best Practice.

[79] IG Guidance; Section II(B)(1); Page 8993.

Enforcement and Discipline

A model Enforcement and Discipline Policy demonstrates a commitment that identified concerns are handled in a professional, unbiased way that solves potential compliance hazards before they cause a problem. An Enforcement and Discipline Policy includes the following provisions: all new employees, volunteers and contractors are checked against the List of Excluded Individuals and Entities (LEIE), discipline is handled fairly and in accordance with the Traditional Discipline and Table of Penalties outlined on the Office of Human Resources Management Website, misconduct is corrected as soon as possible after detection, and violations of law are reported to the proper authorities. Other aspects of an effective policy include: incidents of fraud, waste and abuse (FWA) are reported to the VA OIG, standards for coding, billing and payment are enforced, physician time and attendance is monitored and enforced, corrective action is put in place when deviations from SOP, over/underpayments, material weaknesses or inappropriate employee conduct are discovered. Although the compliance department is not directly responsible for all of these actions, the compliance department must ensure that all of the following practices are taking place without replacing the duties of others.

24. The facility implemented the following components of a model Enforcement and Discipline Program:
    a. Documentation:
        i. *A written Enforcement and Discipline Policy.[80]
        ii. *A written policy regarding the administration of background checks which includes the LEIE. (If yes, attach the document.)[81]

25. Please check “Yes” next to each element that was true about your facility (Please check “Yes” to all that apply. If they were not true of the facility, please check “No” and explain how, or whether, you plan to accomplish this task next fiscal year):
    a. Employees alleged to be involved in misconduct involving CBI matters were removed from that involved job function until an investigation could be completed.
        i. N/A (no employees were alleged to be involved in misconduct involving CBI matters)
    b. *Actual or possible violations of law were reported to the Inspector General and other proper authorities as required by 38 CFR 1.201.
        i. N/A (there were no actual or possible violations of law)
    c. *Actual or possible incidents of Fraud Waste and Abuse were reported to the Office of Inspector General.[82]

[80] Supp. IG Guidance; Section III(B)(7); Page 4876.
[81] Supp. IG Guidance; Section III(B)(7); Page 4876.
[82] VA OIG Briefing Paper; 2003. Supp. OIG Guidance; Section III(B)(6); Page 4876.

i. N/A (there were no actual or possible incidents of FWA)

d. Evidence shows that all employees who violated CBI policies were treated equally.
e. *Standards for coding, billing and refunds were enforced.[83]
f. *Part-time physician time and attendance was monitored and enforced.
    i. Yes.
    ii. No.
    iii. N/A because the facility has no part time physicians.
    iv. If yes, was this a CBI function, or was it monitored by another facility office?
        1. CBI Function.
        2. Other Office (Please Identify).
g. *Corrective action was taken when third party payers identified errors.[84]
h. *Corrective action was taken when a material weakness, systems error or other major problem was identified.[85]
i. Responses to reports of employee misconduct with respect to functional areas that the compliance program oversees were suitable.
    i. N/A because there were no reports of employee misconduct in these functional areas.
j. *All employee misconduct involving CBI matters were entered into the CIRTS database.[86]
    i. N/A because there was no misconduct involving CBI matters.
k. Employees received appropriate recognition when they referred a compliance exception for resolution.
    i. N/A because no employee referred a compliance exception for resolution.

26. Please attach any local policies that support the above statements. If there were no written documents, or there was no policy, please explain why.

*** If your program included all points above, please include your policies and procedures for use as a CBI best practice.

[83] Supp. IG Guidance; Sections I & II; Pages 4858 – 4860.
[84] Supp. IG Guidance; Section III(B)(6); Page 4876.
[85] *Ibid.*
[86] VHA Directive 2001-051; Page 2.

Monitoring and Auditing

Monitoring and Auditing are essential elements of a model Compliance and Business Integrity program. Monitoring is an ongoing internal review of business quality; business operational units conduct monitoring activities as part of internal quality assurance. When done effectively, monitoring is evidence that compliance has become part of the "fabric of operations" as recommended by the HHS OIG. Monitoring typically drives internal process improvements and helps to identify employee educational opportunities. Auditing is performed from outside the business unit; its purpose is to validate the effectiveness of internal monitoring and evaluate the effectiveness of internal controls within the business unit. Key elements of a model Monitoring and Auditing Plan include many things. The Plan is developed after examination of all internal and external reviews (e.g. JCAHO, VA OIG CAP Reviews, SOARS Reviews, VHA Directives, Compliance Effectiveness Bulletins, etc.), the annual medical center Compliance Risk Assessment, and the HHS OIG Work Plan. Frequently, monitoring and auditing results will suggest areas to be monitored in greater detail. The Monitoring and Auditing Plan will specify the areas of business and clinical practice to be monitored and audited throughout the year, who will conduct these audits, the individuals within the facility responsible for reviewing audit results and recommending corrective action, target goals, sample size, and sample selection procedures. All aspects of the revenue cycle, to include external relationships with revenue cycle-related third-party contractors, are monitored and audited during each Fiscal Year. Although external audits are not a requirement of the CBI program, VACO CBI cannot stress enough the importance of validating internal monitors and audits with external reviews. There is also a demonstrated link between the audit results and the facility's Training and Education Plan through training that is targeted at services and activities with identified compliance exceptions.

27. Please check "Yes" next to each element listed below that was part of the Monitoring and Auditing Plan or Policy at your facility: If the element was not part of your medical center's Monitoring and Auditing Program, check "No" and explain how, or whether, you plan to accomplish the task next fiscal year.
    a. *Written plan of what practices were to be audited and monitored throughout the year. (Monitoring and Auditing Plan) (If yes, attach the document.)[87]
    b. *A policy that explains how such monitors and audits would be conducted and who would conduct them. (If yes, attach the document.)[88]
    c. *A Risk Assessment that included a description of the risk identified, the source of the identified risk, a rating of the risk (for

[87] Supp. IG Guidance; Section III(B)(5); Page 4875.
[88] Supp. IG Guidance; Section III(B)(2); Page 4875 ; "Corporate Responsibility and Corporate Compliance;" Page 6; Item 5b.

prioritization purposes) and the mitigation plan (this could have been accomplished by referencing your Monitoring and Auditing Plan, Training and Education Plan, or both). (If yes, attach the document.)[89]

28. Which of the following documents did you consult when developing your Risk Assessment and Monitoring and Auditing Plan?[90]
    a. *The VA OIG Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities
    b. JCAHO reviews.
    c. *The HHS OIG Work Plan.
    d. *Results from monitoring activities.
    e. *Results from auditing activities.
    f. Other documents not listed above (Please List).
    g. N/A (Did not complete a Monitoring and Auditing Plan)

29. *The Monitoring and Auditing Plan was derived from the Risk Assessment.[91]

30. *Periodic reviews of problem areas were conducted to verify that implemented CBI Action Plans have successfully eliminated existing deficiencies or exceptions.[92]

31. Which of the following were true about the facility?
    a. *All aspects and steps of the revenue cycle, including services provided by revenue cycle-related external contractors, were monitored consistently and audited at some point during the fiscal year.[93]
    b. *The facility had a documented and consistently applied statistical sampling methodology for all monitoring and auditing functions.[94]
    c. The facility monitored purchase of non-VA care for possible conflicts of interest.
    d. The compliance department performed internal audits of business functions.
    e. None of the above was true of the facility.

32. Which of the following steps in the Revenue Cycle were monitored last year?[95]
    a. *Patient Intake.

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[89] Supp. IG Guidance; Section III(B)(2); Page 4875 and US Sentencing Guidelines for Organizations at §8B2.1.(c)
[90] Supp. IG Guidance; Section III(B)(2); Page 4875 and VHA Directive 2005-021.
[91] Supp. IG Guidance; Section III(B)(5); Page 4875 and VHA Directive 2005-021.
[92] Supp. IG Guidance; Section III (B) (6); Page 4876 and VHA Directive 2005-021.
[93] Supp. IG Guidance; Section III (B) (5); Page 4875.
[94] IG Guidance, at II(F), and text accompanying. 51, page 8996; Supplemental Guidance, at III(B)(5), page 4875; Sentencing Guidelines, Section 8B2.1(a)(2) and (5)(A) and (C), and Commentary, Section 6(A)(1).
[95] Supp. IG Guidance; Section III(B)(5); Page 4875. VHA Directive 2001-051; Page 2.

b. *Medical Documentation.
c. *Coding.
d. *First and Third party billing.
e. *Utilization Review.
f. *Accounts Receivable.
g. *Third & first party payment application.
h. *Overpayments/Refunds.
i. Others not listed above (Please Specify).

33. Which of the following steps in the Revenue Cycle were audited last year?[96]
    a. *Patient Intake.
    b. *Medical Documentation.
    c. *Coding.
    d. *First and Third party billing.
    e. *Utilization Review.
    f. *Accounts Receivable.
    g. *Third & first party payment application.
    h. *Overpayments/Refunds.
    i. Others not listed above (Please Specify).

34. Who conducted internal monitoring? Choose all that may apply:
    a. Patient Registration.
    b. HIMS.
        i. Which specific areas of documentation or coding? (free text)
    c. Revenue (MCCR, billing and accounts receivable)
        i. Which specific areas of billing or accounts receivable? (free text)
    d. Utilization Review.
    e. Other. (please specify)

35. Were regular, periodic audits conducted by external auditors in the areas of coding, billing and documentation?

36. How often were external audits conducted?
    a. Monthly.
    b. Quarterly.
    c. Annually.
    d. No such audits currently conducted.
    e. Other. (Please Specify)

37. Please provide the dates of your last two external audits.

38. What was the actual cost of the most recent external audit conducted in the last year?
    a. $0
    b. $1 – $10,000

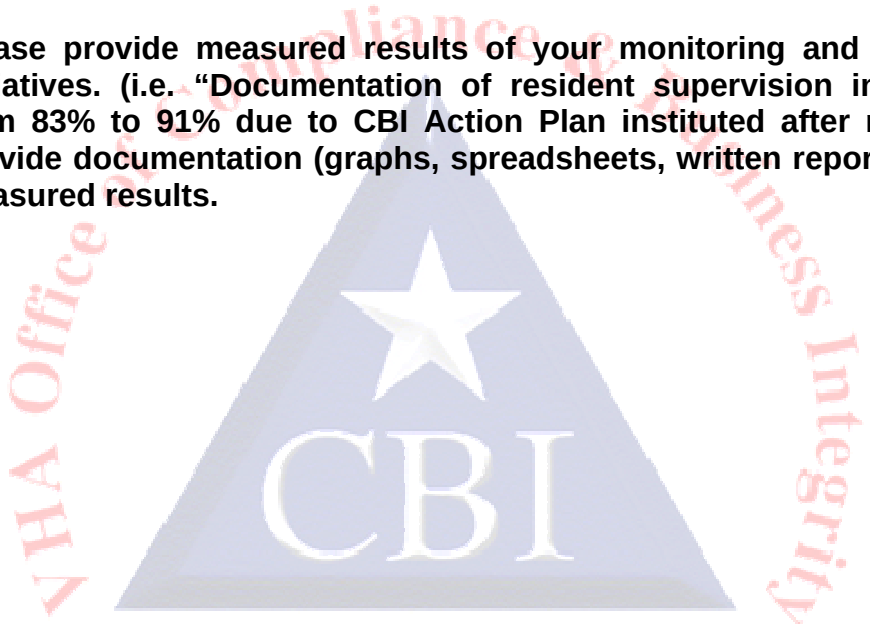
[96] Supp. IG Guidance; Section III(B)(5); Page 4875. VHA Directive 2001-051.

c. $10,001 – $25,000
d. $25,001 - $50,000
e. Greater that $50,000
f. No external audit conducted.

39. Who funded these audits?
    a. Medical Center.
    b. VISN.
    c. Both.
    d. N/A.
    e. Other. (Please Specify)

***If all above statements are checked, please submit any Auditing and Monitoring program documents not already submitted for use as a CBI Best Practice.

40. Please provide measured results of your monitoring and auditing initiatives. (i.e. "Documentation of resident supervision increased from 83% to 91% due to CBI Action Plan instituted after review.") Provide documentation (graphs, spreadsheets, written reports) of all measured results.



Investigation and Response

A model compliance program adheres to formal Investigation and Response Policy Guidance. This guidance describes responsible individuals, structure and process, legal references, expectations and limitations of privacy law as applied to testimony and evidence, union and other representation rights, limitations and expectation of the board among other requirements for a fair and thorough investigation. Informal fact finding investigations do not normally adhere to the requirements outlined in formal Board of Investigation policy. The facility Compliance Program role in the investigation process is best outlined in local policy. For any possible compliance exception discovered during routine business, a prompt inquiry is performed to confirm or rule out a breech of compliance in accordance with VHA Compliance Inquiry Directive 2001-051. All Compliance Inquiries are documented in the CBI CIRTS database as well as VA Form 10-0387 (Compliance Inquiry Form). The Directive incorporates a means to distinguish formal and informal investigations. Should the Compliance inquiry reveal an issue of fraud, waste or abuse then the OIG should be notified in accordance with requirements outlined in OIG policy. Should a violation require a Board of Investigation (as determined by the facility Director or other Convening Authority) then VHA Directive 0700 applies.

Facility Compliance programs should have a documented policy outlining the process of determining which type of investigation is warranted as a suggested approach to an identified exception. This Policy is reviewed by the Compliance Committee and approved by the Facility Director. This policy should include the local process for responding to Helpline calls and outline the local investigation timeline for completion of inquiries and investigations.

CBI Officer may be called upon to serve on Administrative Boards of Investigation that involve known or suspected compliance failures. Regardless of the level of investigation, the CBIO role in the investigation process is to represent the highest ethical standards of conduct and discretion.

Compliance Investigations:

41. Please check “Yes” below each statement that was included in your facility’s Compliance Investigation and Response Program. If the statement was not true about your facility, please check “No” and explain how, or whether, you plan to accomplish the task next fiscal year. [97]
    a. *A written policy outlining how Compliance investigations would be conducted. (If yes, attach the document.)

[97] As to all sub-elements of this question: Supp. IG Guidance; Section III(B)(6); Page 4876 and IG Guidance; Section II(G)(1); Page 8997.

b. The policy was created using all applicable VHA, VISN and VAMC directives, circulars and policies.
c. *The policy describes the local process to accomplish compliance investigations by the CBIO.
d. *The policy was reviewed by the Compliance Committee and approved by the facility director.
e. *The policy included a responsibility matrix for how the facility would respond to investigations.
f. A timeline for opening and closing each investigation/fact-finding effort was included.
g. *There were clear procedures triggering a prompt and thorough fact-finding effort, or an investigation, in the event that a previously undetected compliance exception was discovered.
h. *Every effort was made to protect the reporting individual's identity, (if requested and applicable) while at the same time that individual understood that this might not always be possible.[98]

42. Reporting issues of Fraud, Waste and Abuse to the OIG:
    a. *The CBIO is aware of the organizational requirement to report issues of fraud, waste and abuse to the Office of the Inspector General.[99]
    b. Posters describing the OIG Hotline process are posted prominently.
    c. Posters describing Whistleblower protections are posted prominently.

43. Formal Boards of Investigation[100]:
    a. *The organization has a process in place to comply with VHA Directive 0700 Administrative Investigations dated March 25, 2002. This process includes compliance exceptions, as determined by the Convening Authority, in accordance with Chapter 2 of aforementioned handbook (Determining the need for administrative investigations).
    b. *The Compliance Officer is aware of VHA Handbook 0700 and associated attachments.
    c. *The Compliance Officer serves as a resource to Senior Leadership in determining the need for formal Administrative Boards of Investigation.[101]
    d. *Upon becoming aware of reports, allegations, or evidence of the types of serious incidents outlined in VHA Handbook 0700 Chapter 2, the CBIO immediately notifies the convening authority.[102]

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[98] IG Guidance, at III(D)(2), page 8995; Supplemental Guidance at III(B)(3), page 4875; Sentencing Guidelines, Section 8B2.1(b)(5(C).
[99] 38 CFR 1.201
[100] As to all sub-elements of this question: VA Directive and Handbook 0700.
[101] VHA Handbook 0700, Chapter 1, Section (B)(1); Chapter 3, Section B.
[102] IG Guidance, at III(B)(1), page 8993; II(G)(1), page 8997; Supplemental Guidance, at II(B)(6), page 4876.

e. *The facility refers business failure process issues that result from formal Boards of Investigation to the Compliance Program for follow up analysis or monitoring.[103]

44. The HHS OIG Compliance Guidance for Hospitals advises that each of the following are included in documentation of any internal investigation. Did the facility have a policy that required these elements be included in documentation of formal investigations?[104]
    a. *Background of alleged violation.
    b. *Description of the investigative process.
    c. *Copies of interview notes and the documents reviewed.
    d. *Results of the investigation.
    e. *The Corrective Action Plan implemented.

45. The facility performed at least one audit to ensure that these elements were included in formal investigations

46. *The facility complied with VHA Directive 2001-051 "Compliance Inquiry (CI) Policy" by performing the following activities:[105]
    a. *A Compliance Inquiry was conducted for all compliance failures. (Item 3)
    b. *The Facility Director, VISN Compliance Officer, and Network Director or designee were informed of alleged non-compliance with established standards of business conduct and provided with any information obtained during the inquiry. (Item 4e(3))
    c. *Retained original records pertaining to a CI in accordance with VA records management procedures. (Item 4e(6))
    d. *Provided monthly reports to the Compliance Committee. (Item 4e(7))
    e. *Ensure all CIs are entered into CIRTS and all relevant data is tracked in CIRTS. (Items 4e(1) and 4e(8))
    f. *Complete VA Form 10-0387 for all inquiries requiring investigation. (Item 4e(9))
    g. Percent of compliance inquiries were completed and closed in 30 days. (Item 4e(10))
    h. *Percent of inquiries were entered into CIRTS.

*** If your program included all points in the Investigation and Response section, please submit your Investigation and Response Policy for use as a Best Practice.

[103] IG Guidance at III(F), page 8997; Supplemental Guidelines, at II(B)(6), page 4876; Sentencing Guidelines, Section 8B2.1(b)(7).
[104] IG Guidance; Section II(G)(1); Page 8997
[105] VHA Directive 2001-051; "Compliance Inquiry (CI) Policy"; August 17, 2001

Operational Compliance

In an effort to better understand the structural framework in place and the resources available for compliance programs across the country, CBI instituted a new section of the Annual Report titled "Operational Compliance." Please answer the following questions.

47. What was the Compliance Officer's grade level?
    a. GS-9.
    b. GS-11.
    c. GS-12.
    d. GS-13.
    e. GS-14.
    f. GS-15.
    g. Title-38.
    h. Other (Please specify).

48. What is the highest target grade for the compliance officer position?
    a. GS-9.
    b. GS-11.
    c. GS-12.
    d. GS-13.
    e. GS-14.
    f. GS-15.
    g. Title-38.
    h. Other (Please specify).

49. What is the CBI Officer's Tenure in their present role?
    a. 0-1 Year
    b. 1-2 Years
    c. 2-3 Years
    d. 3-5 Years
    e. More than five years

50. What was the CBI Officer's background prior to becoming a VHA CBIO (Check all that apply)?
    a. MAS.
    b. HIMS.
    c. Private Sector Compliance.
    d. Private Sector Other.
    e. HR.
    f. Legal.
    g. Revenue.
    h. Quality.
    i. Risk Management.
    j. Clinical (Please specify).
    k. Other (Please specify).

51. What is the highest degree the CBI Officer has attained?
    a. Doctorate
    b. Jurist Doctorate
    c. Master's Degree
    d. Bachelor's Degree
    e. Associate's Degree
    f. High School
    g. Other

52. The management level of the Compliance Officer could best be described as which of the following?
    a. Part of the senior management team
    b. Middle management
    c. Supervisor
    d. Individual contributor

53. For what type of organization do you work?
    a. Health System (HCS) – Teaching
    b. Health System (HCS) – Non-teaching
    c. Hospital – Teaching
    d. Hospital – Non-teaching
    e. Other (Please specify)

54. What is the total revenue for your organization? (Need values)

55. How many unique veterans do you serve? (Need values)

56. How many employees does your organization have? (Need values)

57. How often did the CBI Officer meet with the director?

58. How many hours per week does the CBI Officer spend in compliance?
    a. 0 – 10 Hours
    b. 11 – 20 Hours
    c. 21 – 30 Hours
    d. 31 – 40 Hours
    e. More than 40 Hours

59. Did the Compliance Officer have collateral duties?

60. If you responded yes to #49, please check the collateral duties (Check all that apply):
    a. Ethics.
    b. Finance.
    c. HIMS.
    d. Patient Care.
    e. Quality Management.
    f. Research Compliance.
    g. Billing.

h. Coding.
i. Revenue.
j. HIPAA.
k. Other (Please specify all others).

61. How many compliance staff did you supervise?
    a. Zero.
    b. One.
    c. Two.
    d. Three.
    e. Four.
    f. More than four (Please specify).

62. What types of compliance support staff did you supervise (Check all that apply)?
    a. Clerical Support.
    b. Auditors.
    c. Analysts.
    d. Specialists.
    e. Other (Please specify).

63. How many non-compliance staff did you supervise (Collateral Duty)?
    a. Zero.
    b. One.
    c. Two.
    d. Three.
    e. Four.
    f. More than four (Please specify).

64. Did you have a control point for compliance? (If yes, please enter amount allocated.)